DURHAM 1869 CITY OF MEDICINE
HR CONNECT
Human Resources Department
101 CITY HALL PLAZA | DURHAM, NC 27701
919.560.4214 | F 919.560.4969
HRConnect@DurhamNC.gov
www.DurhamNC.gov

Complete your Health Risk Assessment by November 30, 2017.

You have until ***November 30th*** to complete your annual Health Risk Assessment. Completing the assessment makes you eligible to receive a **reimbursement of up to $250** of your 2017/2018 annual medical deductible. It is also the first requirement to receive the reduced wellness rate for your 2018/2019 medical insurance premiums.

The assessment is available online and takes about 15 minutes to complete. Instructions for accessing the health assessment are below, or click here to access video instructions.

If you prefer to complete a paper copy of the health assessment, it is provided below. You must mail your completed paper assessment to:

Alere
9400 North Central Expressway, Suite 700
Dallas, TX 75231

All mailed assessments must be postmarked no later than November 30, 2017. **HR will not be accepting paper forms; they must be mailed to the address provided**.

How to Access the Online Health Risk Assessment

1. Be sure to have your BCBSNC ID card. You will need the subscriber number listed on the card when accessing the assessment for the first time.
2. Go to mybcbsnc.com. Enter your user ID and password. If this is your first time using the website, follow the steps below for registering a user account.
    a. Click on "Register Now"
    b. Be sure you enter your Subscriber ID exactly as it appears on the ID card. The Subscriber ID consists of 8 to 11 numbers, and may contain up to 4 letters.
    c. Enter your date of birth using the following format: mm/dd/yyyy.
    d. Please enter the same ZIP code that is recorded in our records.
3. Once you are logged in with your user ID and password, click on the "Wellness" tab at the top of the page.
4. Next, click on the "Health Assessment" tab located on the left side of the screen.
5. Then follow the instructions on the screen.

Note: *Be sure to complete the online assessment by clicking the "Finish Now!" button at the end of the assessment. Once you finish the assessment, a report will be displayed which includes a wellness score and recommendations pertaining to medical risk factors.*

Please call HR Connect at (919) 560-4214 or email HRConnect@DurhamNC.gov for assistance.

How do I log in to the Health Assessment?

It's easy. Just log in to Blue Connect℠ at *BlueConnectNC.com*

If you are already registered with Blue Connect:

+ Log in to ***BlueConnectNC.com***
+ Click on "**Wellness**" at the top of the page
+ Click on the "**Go to the Health Assessment**" button
+ Answer the questions
+ Review and print your results

Please note: If you use a pop-up blocker you will need to disable it before taking the Health Assessment.

If you have forgotten your User ID:

Below the Member Login box, click Forgot User ID? and follow the online instructions. (You will need your BCBSNC ID card)

If you have forgotten your Password:

Below the Member Login box, click Forgot Password? and follow the online instructions.

If you are NOT already registered with Blue Connect:

+ Make sure you have your BCBSNC ID card available. You will need this information to complete the registration process
+ Go to ***BlueConnectNC.com***
+ Click on "**Register Now**"
+ Be sure you enter your Subscriber # exactly as it appears on the ID card. The Subscriber # is highlighted on the generic sample ID card shown. Your ID card may look different, but the subscriber number will be indicated as it is here, with the phrase "Subscriber #." If the Subscriber # includes letters, there will be between one and four letters. There will always be between eight and 11 numbers.
+ Enter your date of birth using two digits for month, two digits for day and four digits for year.
+ When entering your home zip code, please remember this must be the same ZIP code that we have in our records.

Account setup:

User ID – User ID can be any combination of letters, numbers or special characters, but must be between 6 and 128 characters in length.

Password – Your password must: have no less than 6 characters and no more than 32 characters in length, it must include one non-alphabetical character (a number or symbol, such as @ or %) and cannot contain spaces.

Security Question – As an added measure of security, we ask that you select a question that only you will know the answer to, and provide the answer. If you forget your password later, we will ask you to answer this same question in order to verify your identity. Be sure that the question and answer you select are secure.

E-mail address is required, if you do not have an email address please visit ***yahoo.com*** or ***gmail.com*** and create an e-mail address to be used for registration.

Now that you're on Blue Connect, take the Health Assessment!

The Health Assessment, is provided by Blue Cross and Blue Shield of North Carolina (BCBSNC) through an association with WebMD Inc., a leading provider of health and wellness programs. The purpose of this health risk assessment is to provide you with information to assist in maintaining and improving your health. Information from the Health Assessment may also be used to offer you additional health plan services and programs that are appropriate to your health condition, and which are completely voluntary. This information will not be used to establish your coverage rates, eligibility for coverage or for any employment decisions.

We believe that health information is privileged. This information is considered Protected Health Information (PHI) and will be protected as required by federal law and as described in the "Notice of Privacy Practices" provided to you at enrollment or in your benefit booklet. If you have any questions about completing the questionnaire, please call 1-800-884-5044 Monday through Friday, between 8:30 a.m. and 8 p.m. Eastern Standard Time or e-mail us at healthassessment@webmd.net. BCBSNC reserves the right to discontinue or change this program at any time. BCBSNC provides this program for your convenience and is not liable in any way for the goods or services received. Decisions regarding your care should be made with the advice of your doctor.

FOR MORE INFO

If you need assistance, please call our technical support group at **1-888-705-7050**.

Visit us at ***bcbsnc.com***

BlueCross BlueShield of North Carolina

¿Cómo puedo ingresar a la evaluación de la salud?

Es fácil. Solo ingrese al sitio web para afiliados «Blue Connect℠» en *BlueConnectNC.com*

(disponible únicamente en inglés)

Si ya está registrado para utilizar «Blue Connect»:

+ Ingrese a ***BlueConnectNC.com***
+ Haga un clic en la sección «Wellness» en la parte superior de la página.
+ Haga un clic en el botón «Go to the Health Assessment»
+ Responda a las preguntas
+ Revise e imprima sus resultados

Tome nota: si usted utiliza un bloqueador para ventanas emergentes en Internet tendrá que desactivarlo antes de completar la evaluación.

Si olvidó su nombre de usuario:

Haga un clic en «Forgot User ID?» bajo la casilla para ingresar a «Member Services» y siga las instrucciones. (Necesitará la tarjeta del seguro para completar este proceso).

Si olvidó su contraseña:

Haga un clic en «Forgot Password?» bajo la casilla para ingresar a «Member Services» y siga las instrucciones.

Recuerde que «Member Services» está disponible únicamente en inglés.

Blue Cross and Blue Shield of North Carolina (BCBSNC) proporciona la Evaluación de la salud a través de una colaboración con WebMD Inc., un proveedor líder en programas de salud y bienestar. El propósito de esta evaluación para los riesgos de salud es proporcionarle información para ayudarle a mantener y mejorar su salud. La información de la Evaluación de la salud también se puede utilizar para ofrecerle programas y servicios adicionales apropiados para su condición de salud, los cuales son completamente voluntarios. Esta información no se utilizará para determinar el costo del seguro, elegibilidad para cobertura o para cualquier decisión de empleo.

Mantener información de salud es un privilegio para nosotros. Esta información se considera «Información de salud protegida» (Protected Health Information, PHI) y la protegeremos según lo exigen las leyes federales y de la manera descrita en el «Aviso de normas de privacidad» que se le proporcionó al momento de inscribirse o en su manual de beneficios. Si tiene alguna inquietud relacionada al cuestionario, por favor llame al 1-800-884-5044 (solicite servicio en español) de lunes a viernes, entre las 8:30 am y las 8:00 pm (Hora este) o por correo electrónico a *healthassessment@webmd.com*. BCBSNC se reserva el derecho de cambiar o descontinuar este programa en cualquier momento. BCBSNC proporciona este programa para su conveniencia y no se responsabiliza de ninguna manera por los bienes y servicios recibidos. Las decisiones relacionadas a su atención se deben hacer siguiendo el consejo de su doctor.

Si aun no se ha registrado para utilizar «Blue Connect»:

+ Asegúrese de tener su tarjeta del seguro a la mano. Necesitará esta información para completar el proceso de registro
+ Vaya a ***BlueConnectNC.com***
+ Haga un clic en «Register Now»
+ Es importante ingresar su número de suscriptor exactamente como aparece en la tarjeta del seguro. El número de suscriptor está sombreado en el ejemplo proporcionado en el sitio web. Es posible que su tarjeta sea diferente, pero el número de suscriptor se indicará según aparece en el ejemplo en el sitio web, con la frase «Subscriber #». Si el número de suscriptor incluye letras, habrá entre una y cinco letras. Siempre habrá entre ocho y once números.
+ Ingrese su fecha de nacimiento en el siguiente formato: dos dígitos para el mes, dos dígitos para el día y cuatro dígitos para el año.
+ Al ingresar el código postal, por favor recuerde que debe utilizar el mismo número que tenemos en nuestros expedientes.

Configuración de la cuenta:

Nombre de usuario (User ID) - El nombre de usuario puede ser una combinación de letras, números o caracteres especiales, pero debe tener entre 6 y 128 caracteres.

Contraseña (Password) - Su contraseña debe: tener no menos de 6 y no más de 32 caracteres, debe incluir por lo menos un caracter especial (un número o símbolo, tal como @ o %) y no puede tener espacios.

Pregunta de seguridad (Security Question) - Como medida de seguridad agregada, le pedimos que seleccione una pregunta que solo usted podrá contestar, y proporcione la respuesta. Si luego olvida su contraseña, le haremos esta pregunta para poder verificar su identidad. Asegúrese que la pregunta y respuesta que seleccionó están seguras.

Correo electrónico - Se requiere una dirección de correo electrónico. Si no tiene una, por favor visite ***yahoo.com*** o ***gmail.com*** para crear una cuenta de correo electrónico y utilizarla para propósitos de registro en «Member Services».

Ya que se encuentra en la página «Blue Connect», ¡complete la evaluación de la salud!

¿NECESITA AYUDA?

Si necesita asistencia, por favor llame a nuestro grupo de apoyo técnico al **1-888-705-7050** (solicite servicio en español).

Visítenos en ***bcbsnc.com/azul***

BlueCross BlueShield of North Carolina

BlueCross BlueShield of North Carolina

HealthyOutcomes

BCBSNC Health Assessment

First Name

Last Name

Participant ID Enter the Subscriber # followed by the two digit numeric suffix located on your BCBSNC membership card. You do NOT need to include the first three letters. (If your card shows "YPPW1234567801" enter "W1234567801".)

Date of Birth (mm/dd/yyyy)

Address

City

State

Zip

Group Name

Group Number

When completed, please return to: Alere – 9400 North Central Expressway, Suite 700 – Dallas, TX 75231

RELEASE OF PERSONAL HEALTH INFORMATION

This Health Assessment is provided by Blue Cross and Blue Shield of North Carolina (BCBSNC) through an association with Alere. The purpose of this Health Assessment is to provide you with information to assist in maintaining and improving your health. Participation in this survey and any follow-up contacts based on your results is completely voluntary. In filling out this survey, you will be disclosing Protected Health Information (PHI) that is protected by Federal and State law and will be protected as described in the "Notice of Privacy Practices" provided to you at enrollment or in your benefit booklet. Your survey results will be shared with Alere and BCBSNC to provide additional health plan services and programs for you. Your individual survey results will not be used to establish your insurance coverage rates or your eligibility for coverage. Additionally, your individual survey results will not be shared with your supervisor and will have no bearing on your job status. The PHI you provide will not become part of your personnel or medical record, but may become part of any medical files your employer clinic retains. Your information may only be shared with your employer for wellness program administration, incentive tracking and clinic administration purposes, upon your employer's request. Alere and BCBSNC may use and disclose aggregated, de-identified information obtained from this survey and those of other participants. Personal demographic information is necessary to mail your feedback and administer health improvement programs, if applicable. When completing this survey please do not share any genetic information, including family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you may believe to be at risk. Your completion of this survey is deemed to be your consent to the use or disclosure of your PHI as described above.

Legal Disclaimer: This survey is for informational purposes only, and the information provided herein is not intended to be a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified healthcare provider with any questions you may have regarding a medical condition, any drugs, treatment plans or new symptoms. BCBSNC contracts with Alere Health Improvement Company, an independent third party vendor, for the provision of the Health Assessment, an aspect of Healthy Outcomes, and does not endorse, warrant, or guarantee, and expressly disclaims any and all liability for, any good, product, service, opinion, advice, communication, information or other content made available through this survey. BCBSNC reserves the right to discontinue or change Healthy Outcomes programs at any time.

DEMOGRAPHICS

What is your gender?
◯ Male
◯ Female

What is your relationship to the organization that sponsors your health insurance?
◯ Employee
◯ Retiree
◯ Spouse
◯ Dependent
◯ Other
If you are a spouse or dependent but also an employee, select "Employee"

Do you have a vision impairment that requires special reading materials?
◯ Yes
◯ No

Do you have a hearing impairment that requires special equipment?
◯ Yes
◯ No

Are you comfortable with having conversations in English about medical and health issues?
◯ Yes
◯ No

What is your preferred language for oral (spoken) communication?

_____

What is your preferred language for written communication?

_____

Are you of Hispanic or Latino origin?
◯ Yes
◯ No
◯ I prefer not to answer

What is your race?
◯ American Indian or Alaska Native
◯ Asian
◯ Black or African American
◯ Indian (South Asian)
◯ Pacific Islander/Native Hawaiian
◯ White
◯ Some other race (Check here if you are of mixed race)
◯ I prefer not to answer

What is your current marital status?
◯ Single
◯ Married
◯ Separated
◯ Divorced
◯ Widowed
◯ Other

What is the highest grade or level of school that you have completed?
◯ 8th grade or less
◯ Some high school, but did not graduate
◯ High school graduate or GED
◯ Some college or 2-year degree
◯ 4-year college graduate
◯ More than 4-year college degree

HEALTH HISTORY

In general, considering your age would you say your health is:
◯ Excellent
◯ Very good
◯ Good
◯ Fair
◯ Poor

In general, how would you rate your overall mental health now?
◯ Excellent
◯ Very good
◯ Good
◯ Fair
◯ Poor

Do you have or have you had any of the following health problems?

Arthritis, osteoarthritis	◯ Yes	◯ No
Asthma	◯ Yes	◯ No
Cancer	◯ Yes	◯ No
Chronic pain (for example: chronic back pain, sciatica, chronic neck pain, fibromyalgia)	◯ Yes	◯ No
Congestive heart failure	◯ Yes	◯ No
Depression	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No
Heart disease (for example: angina, heart attack, heart surgery, atrial fibrillation, etc.)	◯ Yes	◯ No
Headaches (for example: migraines, or severe and/or frequent headaches)	◯ Yes	◯ No
High blood pressure/hypertension	◯ Yes	◯ No
High blood cholesterol (or low HDL cholesterol)	◯ Yes	◯ No
Lung disease (for example: chronic obstructive pulmonary disease/COPD; emphysema; chronic bronchitis)	◯ Yes	◯ No
Stroke	◯ Yes	◯ No

Do you have or have you had any of the following health problems?

Allergies (seasonal) or hay fever	◯ Yes	◯ No
Anxiety disorder	◯ Yes	◯ No
Chronic fatigue or low energy	◯ Yes	◯ No
Digestive disorder (for example: irritable bowel ulcerative colitis, or Crohn's disease)	◯ Yes	◯ No
Heartburn or acid reflux (GERD)	◯ Yes	◯ No
Overweight or obesity	◯ Yes	◯ No
Osteoporosis	◯ Yes	◯ No
Sleep disorder (such as sleep apnea, insomnia, or other chronic sleeping problem)	◯ Yes	◯ No
Ulcer (stomach or intestinal)	◯ Yes	◯ No
Urinary or bladder problems	◯ Yes	◯ No

IF YES TO ARTHRITIS…

What type (s) of arthritis / joint pain do you have or have you had?

Osteoarthritis	◯ Yes	◯ No
Rheumatoid arthritis	◯ Yes	◯ No
Other joint pain	◯ Yes	◯ No

IF YES TO CANCER…

What type(s) of cancer do you have or have you had?

Breast cancer.	◯ Yes	◯ No
Cancer of the colon or rectum	◯ Yes	◯ No
Cervical cancer	◯ Yes	◯ No
Lung cancer	◯ Yes	◯ No
Ovarian cancer	◯ Yes	◯ No
Prostate cancer	◯ Yes	◯ No
Skin cancer (melanoma)	◯ Yes	◯ No
Other cancer	◯ Yes	◯ No

IF YES TO DIABETES…

What type of diabetes diagnosis do you have or have you had?

Type 1 (formerly "juvenile onset," but may occur in adults)	◯ Yes	◯ No
Type 2 (formerly "adult onset," but may occur in children)	◯ Yes	◯ No

IF YES TO HEADACHES…

What type(s) of headaches do you have or have you had?

Migraine headaches	◯ Yes	◯ No
Tension headaches	◯ Yes	◯ No
Other severe/frequent headaches	◯ Yes	◯ No

IF YES TO LUNG DISEASE…

What lung disease diagnosis do you have or have you had?

Chronic obstructive pulmonary disease (COPD)	◯ Yes	◯ No
Chronic bronchitis	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No
Other lung disease	◯ Yes	◯ No

IF YES TO CHRONIC PAIN…

What types(s) of chronic pain do you have or have you had?

Chronic low back pain or sciatica	◯ Yes	◯ No
Chronic neck pain	◯ Yes	◯ No
Fibromyalgia	◯ Yes	◯ No
Other chronic pain	◯ Yes	◯ No

IF YES TO DIGESTIVE DISORDER…

What digestive disorder diagnoses do you have or have you had?

Irritable bowel syndrome	◯ Yes	◯ No
Ulcerative colitis	◯ Yes	◯ No
Crohn's disease	◯ Yes	◯ No
Other digestive disease	◯ Yes	◯ No

IF YES TO SLEEP DISORDER…

What type(s) of sleep disorder do you have or have you had?

Sleep apnea	◯ Yes	◯ No
Insomnia (frequent or chronic)	◯ Yes	◯ No
Other sleep disorder	◯ Yes	◯ No

IF YES TO ASTHMA...

How often would you estimate that you have asthma symptoms?
- ◯ Twice a week or less
- ◯ Less than once a day, but more than twice a week
- ◯ At least 1 time per day
- ◯ More than 1 time per day

How often would you estimate that you have asthma symptoms at night?
- ◯ Two times per month or less
- ◯ More than 2 times per month, but less than once a week
- ◯ 1-4 nights per week
- ◯ Frequently (More than half the nights during the week)

Which statement best describes how often your asthma symptoms interfere with your ability to carry out your normal daily activities?
- ◯ My asthma rarely interferes with my normal activities.
- ◯ Sometimes my activities are limited when I have an asthma attack.
- ◯ My activities are limited when I have an asthma attack.

IF YES TO HEART DISEASE...

What heart disease diagnoses or procedures do you have or have you had?
- ◯ Angina (Chest pain)
- ◯ Angioplasty (Catheterization with or without stent)
- ◯ Atrial fibrillation
- ◯ Bypass surgery (Coronary artery bypass graft/CABG)
- ◯ Heart attack
- ◯ Other heart disease

IF YES TO CHRONIC PAIN...

Has your pain lasted for more than 3 months?

Low back pain or sciatica
- ◯ Yes
- ◯ No

Neck pain
- ◯ Yes
- ◯ No

Fibromyalgia
- ◯ Yes
- ◯ No

Other chronic pain
- ◯ Yes
- ◯ No

Osteoarthritis
- ◯ Yes
- ◯ No

Rheumatoid arthritis
- ◯ Yes
- ◯ No

Other joint pain
- ◯ Yes
- ◯ No

Migraine headaches
- ◯ Yes
- ◯ No

Tension headaches
- ◯ Yes
- ◯ No

Other severe/frequent headaches
- ◯ Yes
- ◯ No

Do you still have pain despite current treatment?

Low back pain or sciatica
- ◯ Yes
- ◯ No

Neck pain
- ◯ Yes
- ◯ No

Fibromyalgia
- ◯ Yes
- ◯ No

Other chronic pain
- ◯ Yes
- ◯ No

Osteoarthritis
- ◯ Yes
- ◯ No

Rheumatoid arthritis
- ◯ Yes
- ◯ No

Other joint pain
- ◯ Yes
- ◯ No

Migraine headaches
- ◯ Yes
- ◯ No

Tension headaches
- ◯ Yes
- ◯ No

Other severe/frequent headaches
- ◯ Yes
- ◯ No

Does this condition affect your ability to function?

Low back pain or sciatica
◯ Yes
◯ No

Neck pain
◯ Yes
◯ No

Fibromyalgia
◯ Yes
◯ No

Other chronic pain
◯ Yes
◯ No

Osteoarthritis
◯ Yes
◯ No

Rheumatoid arthritis
◯ Yes
◯ No

Other joint pain
◯ Yes
◯ No

Migraine headaches
◯ Yes
◯ No

Tension headaches
◯ Yes
◯ No

Other severe/frequent headaches
◯ Yes
◯ No

During the past year, how many days have you missed from work because you were either ill or injured? (Do not include days you may have missed because of someone else's illness or injury.)

◯ 0 days
◯ 1-2 days
◯ 3-5 days
◯ 6-10 days
◯ 11-15 days
◯ 16 or more days

CURRENT HEALTH

Are you currently receiving treatment or have you ever received treatment for:

Allergies (seasonal) or hay fever
- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Anxiety disorder
- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Arthritis, osteoarthritis
- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Arthritis, rheumatoid
- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Other joint pain
- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Asthma
- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Cancer, breast
- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Cancer, colon/rectal
- ◯ I have never received professional treatment for this condition.
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Cancer, cervical
- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Cancer, lung
- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Cancer, ovarian
- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Cancer, prostate
- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Cancer, skin (melanoma)
- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Cancer, other

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Chronic fatigue or low energy

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Chronic pain, back pain or sciatica

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Chronic pain, neck

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Chronic pain, other

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Congestive heart failure

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Depression

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Diabetes

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Digestive disorder, irritable bowel syndrome

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Digestive disorder, ulcerative colitis

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Digestive disorder, Crohn's disease

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Digestive disorder, other

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Heart disease

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Headaches, severe/frequent

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Headaches, migraines

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Headaches, tension

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Headaches, other severe/frequent

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Heartburn or acid reflux (GERD)

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

High blood pressure/hypertension

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

High blood cholesterol (or low HDL cholesterol)

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Lung disease, chronic obstructive pulmonary disease/COPD

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Lung disease, chronic bronchitis

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Lung disease, emphysema

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Lung disease, other

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Obesity

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Osteoporosis

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Stroke

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Sleep disorder

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Sleep Apnea

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Other chronic sleeping problem

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Ulcer (stomach or intestinal)

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Urinary or bladder problems

- ◯ I have never received professional treatment for this condition
- ◯ I previously received (but do not currently receive) professional treatment for this condition
- ◯ I currently receive professional treatment for this condition

Are you currently taking prescription or over-the counter medication for:

Allergies (seasonal) or hay fever	◯ Yes	◯ No
Anxiety disorder	◯ Yes	◯ No
Arthritis, osteoarthritis	◯ Yes	◯ No
Arthritis, rheumatoid	◯ Yes	◯ No
Other joint pain	◯ Yes	◯ No
Asthma	◯ Yes	◯ No
Cancer, breast	◯ Yes	◯ No
Cancer, colon/rectal	◯ Yes	◯ No
Cancer, cervical	◯ Yes	◯ No
Cancer, lung	◯ Yes	◯ No
Cancer, ovarian	◯ Yes	◯ No
Cancer, prostate	◯ Yes	◯ No
Cancer, skin (melanoma)	◯ Yes	◯ No
Cancer, other	◯ Yes	◯ No
Chronic fatigue or low energy	◯ Yes	◯ No
Chronic pain, back pain or sciatica	◯ Yes	◯ No
Chronic pain, neck	◯ Yes	◯ No
Chronic pain, other	◯ Yes	◯ No
Congestive heart failure	◯ Yes	◯ No
Depression	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No
Digestive disorder, irritable bowel syndrome	◯ Yes	◯ No
Digestive disorder, ulcerative colitis	◯ Yes	◯ No
Digestive disorder, Crohn's disease	◯ Yes	◯ No
Digestive disorder, other	◯ Yes	◯ No
Heart disease	◯ Yes	◯ No
Headaches, severe and/or frequent	◯ Yes	◯ No
Headaches, migraines	◯ Yes	◯ No
Headaches, tension	◯ Yes	◯ No
Heartburn or acid reflux (GERD)	◯ Yes	◯ No
High blood pressure/hypertension	◯ Yes	◯ No
High blood cholesterol (or low HDL cholesterol)	◯ Yes	◯ No
Lung disease, chronic obstructive pulmonary disease/COPD	◯ Yes	◯ No
Lung disease, chronic bronchitis	◯ Yes	◯ No
Lung disease, emphysema	◯ Yes	◯ No
Lung disease, other	◯ Yes	◯ No

Obesity	○ Yes	○ No
Osteoporosis	○ Yes	○ No
Stroke	○ Yes	○ No
Sleep disorder	○ Yes	○ No
Sleep Apnea	○ Yes	○ No
Other chronic sleeping problem	○ Yes	○ No
Ulcer (stomach or intestinal)	○ Yes	○ No
Urinary or bladder problems	○ Yes	○ No

PHYSICAL ACTIVITY

Consider any high intensity activity that you do (see examples below). In a typical week, how many days do you get at least 20 minutes of high intensity physical activity? You may count any high intensity activity that you do that lasts at least 10 minutes at a time.

> **High intensity** activities are activities that increase your heart rate, make you sweat, and may make you feel out of breath. Examples include jogging, running, fast cycling, aerobics classes, swimming laps, singles tennis, etc.

◯ 7 days per week
◯ 6 days per week
◯ 5 days per week
◯ 4 days per week
◯ 3 days per week
◯ 2 days per week
◯ 1 day per week
◯ 0 days per week

On days that you do high intensity physical activity, how many minutes do you typically get per day?

_____ minutes

Now consider only the moderate intensity activity that you do (see examples below). In a typical week, how many days do you get at least 30 minutes of moderate intensity physical activity? You may count any moderate intensity activity that you do that lasts at least 10 minutes at a time.

> **Moderate intensity** activities are activities that require more effort than is needed to carry out typical everyday tasks. Examples include brisk walking, gardening, slow cycling, dancing, doubles tennis, etc.

◯ 7 days per week
◯ 6 days per week
◯ 5 days per week
◯ 4 days per week
◯ 3 days per week
◯ 2 days per week
◯ 1 day per week
◯ 0 days per week

On days that you do moderate intensity physical activity, how many minutes do you typically get per day?

_____ minutes

During a typical week, how often do you do resistance or strength training?

◯ 7 days per week
◯ 6 days per week
◯ 5 days per week
◯ 4 days per week
◯ 3 days per week
◯ 2 days per week
◯ 1 day per week
◯ 0 days per week

During a typical week, how often do you do stretching or flexibility exercises?

◯ 7 days per week
◯ 6 days per week
◯ 5 days per week
◯ 4 days per week
◯ 3 days per week
◯ 2 days per week
◯ 1 day per week
◯ 0 days per week

NUTRITION

How many servings of each of the following types of food do you eat in a typical day?

Fruit

◯ 0 serving
◯ 1 serving
◯ 2 servings
◯ 3 servings
◯ 4 servings
◯ 5 servings
◯ 6 servings
◯ 7 servings
◯ 8 servings
◯ 9 or more servings

Vegetables

◯ 0 serving
◯ 1 serving
◯ 2 servings
◯ 3 servings
◯ 4 servings
◯ 5 servings
◯ 6 servings
◯ 7 servings
◯ 8 servings
◯ 9 or more servings

Whole grain breads, cereals, rice or pastas

◯ 0 serving
◯ 1 serving
◯ 2 servings
◯ 3 servings
◯ 4 servings
◯ 5 servings
◯ 6 servings
◯ 7 servings
◯ 8 servings
◯ 9 or more servings

Dairy or calcium-fortified products

◯ 0 serving
◯ 1 serving
◯ 2 servings
◯ 3 servings
◯ 4 servings
◯ 5 servings
◯ 6 servings
◯ 7 servings
◯ 8 servings
◯ 9 or more servings

Meats/poultry/fish/cooked dry beans/eggs/nuts

◯ 0 serving
◯ 1 serving
◯ 2 servings
◯ 3 servings
◯ 4 servings
◯ 5 servings
◯ 6 servings
◯ 7 servings
◯ 8 servings
◯ 9 or more servings

Based on your typical food choices, how would you describe the amount of fat in your diet?

High fat food sources include: hamburgers, sausages, luncheon meats, sour cream, cheeses, eggs, butter, margarine, oils, regular salad dressings, whole-fat dairy products, ice cream, pastries, chocolate, fried foods, and most fast foods.

◯ High in fat
◯ Somewhat high in fat
◯ Neither high nor low in fat
◯ Somewhat low in fat
◯ Low in fat

On a typical day, how often do you take steps to limit the amount of fat in the foods you eat?
◯ Always or almost always
◯ Most of the time
◯ Some of the time
◯ Rarely or never

TOBACCO USE

Do you currently use any of the following tobacco products?

Cigarettes
◯ Daily ◯ Not any more
◯ Only some days ◯ Never used

Cigars
◯ Daily ◯ Not any more
◯ Only some days ◯ Never used

Pipes
◯ Daily ◯ Not any more
◯ Only some days ◯ Never used

Smokeless tobacco
◯ Daily ◯ Not any more
◯ Only some days ◯ Never used

IF YES TO CIGARETTES...

On the average, on days that you smoke, about how many cigarettes a day do you now smoke?
◯ 1 to 9 cigarettes per day
◯ 10-19 cigarettes per day
◯ 20-39 cigarettes per day
◯ 40 or more cigarettes per day

For each type of tobacco that you quit using, how long has it been since your last use? (Leave blank for each type of tobacco that you still use or that you have never used)

IF YES TO CIGARETTES...
◯ Within the past 30 days
◯ 30 days ago or more, but within the past 6 months
◯ 6 months ago or more, but within the past 2 months
◯ 12 months (1 year) ago or more, but within the past 3 years
◯ 3 years ago or more, but within the past 5 years
◯ 5 years ago or more, but within the past 10 years
◯ 10 years ago or more

IF YES TO CIGARS...
◯ Within the past 30 days
◯ 30 days ago or more, but within the past 6 months
◯ 6 months ago or more, but within the past 12 months
◯ 12 months (1 year) ago or more, but within the past 3 years
◯ 3 years ago or more, but within the past 5 years
◯ 5 years ago or more, but within the past 10 years
◯ 10 years ago or more

IF YES TO PIPES...
◯ Within the past 30 days
◯ 30 days ago or more, but within the past 6 months
◯ 6 months ago or more, but within the past 12 months
◯ 12 months (1 year) ago or more, but within the past 3 years
◯ 3 years ago or more, but within the past 5 years
◯ 5 years ago or more, but within the past 10 years
◯ 10 years ago or more

IF YES TO SMOKELESS TOBACCO...
◯ Within the past 30 days
◯ 30 days ago or more, but within the past 6 months
◯ 6 months ago or more, but within the past 12 months
◯ 12 months (1 year) ago or more, but within the past 3 years
◯ 3 years ago or more, but within the past 5 years
◯ 5 years ago or more, but within the past 10 years
◯ 10 years ago or more

Do you live or work with anyone who often smokes around you?
◯ Yes
◯ No

ALCOHOL USE

On average, how many alcoholic drinks do you have during a typical week? (Alcoholic drinks include beer, wine, wine coolers, liquor and liqueurs.)

Examples of one drink are:

- **1 measure of liquor (1.5 oz of 80 proof)**
- **12 ounces of beer**
- **1 glass (5 oz) of wine**
- **12 ounce wine cooler**

◯ 0 drinks/week, I have never drunk alcohol
◯ 0 drinks/week, I quit drinking alcohol
◯ Less than 1 drink/week
◯ 1-7 drinks/week
◯ 8-14 drinks/week
◯ 15-21 drinks/week
◯ 22-28 drinks/week
◯ 29 or more drinks/week

During the past month, what is the maximum number of alcoholic drinks that you have had on any single day?
◯ 0-1 drink
◯ 2 drinks
◯ 3 drinks
◯ 4 drinks
◯ 5 or more drinks

Are any of the following statements true for you?

Have you ever felt that you should cut down on your drinking?
◯ Yes ◯ No

Have people annoyed you by criticizing your drinking?
◯ Yes ◯ No

Have you ever felt bad or guilty about your drinking?
◯ Yes ◯ No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
◯ Yes ◯ No

STRESS

In general, how often is stress a problem for you?
◯ Very often
◯ Often
◯ Sometimes
◯ Rarely or never

How well do you feel you are coping with the stress in your life?
◯ I am coping very well
◯ I am coping fairly well
◯ I sometimes have trouble coping
◯ I often have trouble coping

Over the past month, how much has stress affected your health or interfered with your ability to do your job well or to enjoy your personal life?
◯ Quite a bit
◯ Somewhat
◯ Very little or not at all

In general, how satisfied are you with your life? (personal, family, work, social, etc.)
◯ Completely satisfied
◯ Mostly satisfied
◯ Partly satisfied
◯ Not satisfied

Would you agree you are satisfied with your job?
◯ Agree strongly
◯ Agree
◯ Disagree
◯ Disagree strongly
◯ Not applicable; I am not employed

Have you suffered a personal loss or misfortune in the past year? (For example: a job loss, disability, divorce, separation, jail term, or the death of someone close to you)
◯ Yes, two or more serious losses
◯ Yes, one serious loss
◯ No

In general, how strong are your social ties with your family and/or friends?
◯ Very strong
◯ About average
◯ Weaker than average
◯ Not sure

How often do you use drugs or medication (including prescription drugs) which affect your mood or help you relax?
◯ Almost every day
◯ Sometimes
◯ Rarely

SLEEP

On the average, how many hours of sleep do you get per night?
◯ Less than 5 hours
◯ 5 hours or more, but less than 6 hours
◯ 6 hours or more, but less than 7 hours
◯ 7 hours or more, but less than 8 hours
◯ 8 hours or more, but less than 9 hours
◯ 9 hours or more

During a typical week, how sleepy are you during your waking hours?
◯ Extremely sleepy; I'm frequently sleepy even when I'm active (for example, when driving or in conversation)
◯ Very sleepy; I'm sometimes sleepy even when I'm active (for example, when driving or in conversation)
◯ Moderately sleepy; sleepiness occurs when I am resting or not active, but rarely occurs when I am active.
◯ Mildly sleepy; sleepiness sometimes occurs when I am resting or not active.
◯ I am rarely sleepy during my waking hours

On the average, in the past month, how often have you snored or been told that you snored?
◯ Never
◯ Rarely (0-1 time per week)
◯ Sometimes (1-2 times per week)
◯ Frequently (3-4 times per week)
◯ Almost always (5-7 times per week)

On the average, in the past month, how often do you wake up choking or gasping?
◯ Never
◯ Rarely (0-1 time per week)
◯ Sometimes (1-2 times per week)
◯ Frequently (3-4 times per week)
◯ Almost always (5-7 times per week)

On the average, in the past month, how often have you been told that you stop breathing in your sleep?
◯ Never
◯ Rarely (0-1 time per week)
◯ Sometimes (1-2 times per week)
◯ Frequently (3-4 times per week)
◯ Almost always (5-7 times per week)

SAFETY

How often do you wear a seat belt when driving or riding in a car, truck, or van?
◯ Always
◯ Most of the time
◯ Sometimes
◯ Rarely or never

How many times in the last month have you driven when you have had perhaps too much to drink (or ridden when the driver has had perhaps too much to drink)?
◯ Never
◯ 1-3 times
◯ 4 or more times

How close to the speed limit do you usually drive?
◯ More than 5 mph under the posted limit
◯ Within 5 mph of the posted limit
◯ 6-10 mph over the posted limit
◯ 11-15 mph over the posted limit
◯ More than 15 mph over the posted limit
◯ Not applicable, I do not drive

MENTAL HEALTH

During the past month, have you often been bothered by feeling down, depressed, or hopeless?
◯ Yes
◯ No

During the past month, have you often been bothered by little or no interest or pleasure in doing things?
◯ Yes
◯ No

If you said "Yes" to either of the items above, please answer the next two items.

Did these feelings ever last for 2 weeks or more at a time?
◯ Yes
◯ No

Do these feelings interfere with your ability to do your job well or to enjoy your personal life?
◯ Yes
◯ No

Over the past 6 months have you ever felt so anxious or worried that it interfered with your ability to work at your job or in the home?
◯ Yes
◯ No

If you said "Yes" to the item above, please answer the next two items.

Did your anxiety ever last for 2 weeks or more at a time?
◯ Yes
◯ No

Does anxiety interfere with your ability to do your job well or to enjoy your personal life?
◯ Yes
◯ No

BIOMETRICS 1

What units of measure do you want to enter...
◯ Feet/Inches and Pounds
◯ Centimeters and Kilograms

Please enter your height and weight below. If you are a female and are currently pregnant, please enter your pre-pregnancy weight.

Height

_____ Enter Value

Weight

_____ Enter Value

Do you think you have a greater than average amount of muscle mass as a result of the activity you do on and off your job?
◯ Yes
◯ No

Please enter your waist size below. If you are a female and are currently pregnant, please enter your pre-pregnancy waist size.

_____ Enter Value

Is your waist 40 inches or smaller OR 102 centimeters or smaller? (Males)
◯ Yes
◯ No

Is your waist 35 inches or smaller OR 88 centimeters or smaller? (Females)
◯ Yes
◯ No

STAGE OF CHANGE

Which of the following statements best describes your plans about managing your weight?

- ◯ At this time, I have no interest in making changes to manage my weight.
- ◯ I am concerned about my weight, and I am thinking about making changes to lose weight or manage my weight more effectively in the next 6 months.
- ◯ I am concerned about my weight, and I am getting ready to make changes to lose weight or manage my weight more effectively in the next 30 days.
- ◯ I lost weight or made changes to my weight management habits in the last 6 months, and I am working to make those changes a permanent part of my lifestyle.
- ◯ I lost weight or made changes to my weight management habits over 6 months ago, and I am continuing to work to make those changes a permanent part of my lifestyle.
- ◯ At some point in the past I chose healthy weight management habits, and now they seem natural and almost effortless to continue.

For each lifestyle area listed below, select the statement that best describes your readiness to make lifestyle changes in that area.

Being more physically active

- ◯ Not thinking about making changes in the next 6 months
- ◯ Thinking about making changes in the next 6 months
- ◯ Getting ready to make changes in the next 30 days
- ◯ Have just made changes within the past 6 months
- ◯ Working on maintaining changes I made over 6 months ago
- ◯ Maintaining changes I made over 6 months ago seems natural/effortless
- ◯ Not applicable, I am not interested in making changes

Improving my diet

- ◯ Not thinking about making changes in the next 6 months
- ◯ Thinking about making changes in the next 6 months
- ◯ Getting ready to make changes in the next 30 days
- ◯ Have just made changes within the past 6 months
- ◯ Working on maintaining changes I made over 6 months ago
- ◯ Maintaining changes I made over 6 months ago seems natural/effortless
- ◯ Not applicable, I am not interested in making changes

Better managing stress

- ◯ Not thinking about making changes in the next 6 months
- ◯ Thinking about making changes in the next 6 months
- ◯ Getting ready to make changes in the next 30 days
- ◯ Have just made changes within the past 6 months
- ◯ Working on maintaining changes I made over 6 months ago
- ◯ Maintaining changes I made over 6 months ago seems natural/effortless
- ◯ Not applicable, I am not interested in making changes

Select the statement that best describes your "readiness to change" for each of the following substances:

Cigarettes

- ◯ Not thinking about quitting/cutting down in the next 6 months
- ◯ Thinking about quitting/cutting down in the next 6 months
- ◯ Getting ready to quit/cut down in the next 30 days
- ◯ Just quit/cut down within the past 6 months
- ◯ Quit/cut down 6+ months ago; working on maintenance
- ◯ Quit/cut down 6+ months ago; maintenance seems natural/effortless
- ◯ I have never smoked cigarettes
- ◯ Not applicable, I am not interested in making changes

Cigars

- ◯ Not thinking about quitting/cutting down in the next 6 months
- ◯ Thinking about quitting/cutting down in the next 6 months
- ◯ Getting ready to quit/cut down in the next 30 days
- ◯ Just quit/cut down within the past 6 months
- ◯ Quit/cut down 6+ months ago; working on maintenance
- ◯ Quit/cut down 6+ months ago; maintenance seems natural/effortless
- ◯ I have never smoked cigars
- ◯ Not applicable, I am not interested in making changes

Pipes
- ◯ Not thinking about quitting/cutting down in the next 6 months
- ◯ Thinking about quitting/cutting down in the next 6 months
- ◯ Getting ready to quit/cut down in the next 30 days
- ◯ Just quit/cut down within the past 6 months
- ◯ Quit/cut down 6+ months ago; working on maintenance
- ◯ Quit/cut down 6+ months ago; maintenance seems natural/effortless
- ◯ I have never smoked pipes
- ◯ Not applicable, I am not interested in making changes

Smokeless Tobacco
- ◯ Not thinking about quitting/cutting down in the next 6 months
- ◯ Thinking about quitting/cutting down in the next 6 months
- ◯ Getting ready to quit/cut down in the next 30 days
- ◯ Just quit/cut down within the past 6 months
- ◯ Quit/cut down 6+ months ago; working on maintenance
- ◯ Quit/cut down 6+ months ago; maintenance seems natural/effortless
- ◯ I have never used smokeless tobacco
- ◯ Not applicable, I am not interested in making changes

Alcohol
- ◯ Not thinking about quitting/cutting down in the next 6 months
- ◯ Thinking about quitting/cutting down in the next 6 months
- ◯ Getting ready to quit/cut down in the next 30 days
- ◯ Just quit/cut down within the past 6 months
- ◯ Quit/cut down 6+ months ago; working on maintenance
- ◯ Quit/cut down 6+ months ago; maintenance seems natural/effortless
- ◯ I have never consumed alcohol
- ◯ Not applicable, I am not interested in making changes

How confident are you that you will be able to make and/or maintain changes in the following areas of your lifestyle?

Improving the way I manage my weight
- ◯ Extremely confident
- ◯ Very confident
- ◯ Moderately confident
- ◯ Slightly confident
- ◯ Not at all confident

Increasing and/or maintaining my level of physical activity
- ◯ Extremely confident
- ◯ Very confident
- ◯ Moderately confident
- ◯ Slightly confident
- ◯ Not at all confident

Improving the quality of my diet
- ◯ Extremely confident
- ◯ Very confident
- ◯ Moderately confident
- ◯ Slightly confident
- ◯ Not at all confident

Improving the way I handle stress
- ◯ Extremely confident
- ◯ Very confident
- ◯ Moderately confident
- ◯ Slightly confident
- ◯ Not at all confident

Quitting or cutting down on my use of cigarettes
- ◯ Extremely confident
- ◯ Very confident
- ◯ Moderately confident
- ◯ Slightly confident
- ◯ Not at all confident

Quitting or cutting down on my use of cigars
- ◯ Extremely confident
- ◯ Very confident
- ◯ Moderately confident
- ◯ Slightly confident
- ◯ Not at all confident

Quitting or cutting down on my use of pipes
- ◯ Extremely confident
- ◯ Very confident
- ◯ Moderately confident
- ◯ Slightly confident
- ◯ Not at all confident

Quitting or cutting down on my use of smokeless tobacco
- ◯ Extremely confident
- ◯ Very confident
- ◯ Moderately confident
- ◯ Slightly confident
- ◯ Not at all confident

Quitting or cutting down on my use of alcohol
- ◯ Extremely confident
- ◯ Very confident
- ◯ Moderately confident
- ◯ Slightly confident
- ◯ Not at all confident

SCREENINGS/IMMUNIZATIONS

How long has it been since your last physical examination by a physician?
◯ Less than one year
◯ 1-2 years ago
◯ More than 2 years ago
◯ Never
◯ Don't know

How long has it been since you last had your blood cholesterol checked?
◯ Less than one year
◯ 1-2 years ago
◯ 2-5 years ago
◯ More than 5 years ago
◯ Never
◯ Don't know

How long has it been since you last had your blood pressure checked?
◯ Less than one year
◯ 1-2 years ago
◯ More than 2 years ago
◯ Never
◯ Don't know

How long has it been since your last colorectal exam or test? Since there are several test options, please indicate how long it has been for each type of exam/test.

Fecal occult blood test (a test for blood in your stool)
◯ I have never had this test
◯ Within the past year
◯ 1-2 years ago
◯ 3-5 years ago
◯ 6-10 years ago
◯ Over 10 years ago

Double contrast barium enema
◯ I have never had this test
◯ Within the past year
◯ 1-2 years ago
◯ 3-5 years ago
◯ 6-10 years ago
◯ Over 10 years ago

Flexible sigmoidoscopy
◯ I have never had this test
◯ Within the past year
◯ 1-2 years ago
◯ 3-5 years ago
◯ 6-10 years ago
◯ Over 10 years ago

Colonoscopy or virtual colonoscopy
◯ I have never had this test
◯ Within the past year
◯ 1-2 years ago
◯ 3-5 years ago
◯ 6-10 years ago
◯ Over 10 years ago

Have you been immunized or received a shot for:

Flu (in the last year)
◯ Yes
◯ No
Tetanus (in the last 10 years)
◯ Yes
◯ No
Pneumonia (ever)
◯ Yes
◯ No
Measles/Mumps/Rubella (ever)
◯ Yes
◯ No
Varicella/Zoster (Chickenpox) (ever)
◯ Yes
◯ No
Human papillomavirus (HPV) (ever)
◯ Yes
◯ No
Hepatitis B (ever)
◯ Yes
◯ No

How long has it been since you last had your vision checked?
◯ Less than one year ago
◯ 1-2 years ago
◯ 2-5 years ago
◯ More than 5 years ago
◯ Never
◯ Don't know

How long has it been since your last dental check-up?
◯ Six months ago or less
◯ 7 months to 12 months ago
◯ More than 12 months ago

If you have been sexually active with more than one partner in the past 12 months, how often did you use barrier protection, such as a latex condom?
◯ I never use protection
◯ I seldom use protection
◯ I sometimes use protection
◯ I always use protection
◯ Not applicable
◯ I prefer not to answer

FOR FEMALES ONLY

Are you currently pregnant?
◯ Yes
◯ No
◯ Don't know
◯ I am planning to become pregnant in the next 6 months

How often do you examine your breasts for lumps?
◯ Not applicable
◯ Monthly
◯ Once every few months
◯ Rarely or never

How long has it been since your last mammogram (breast X-ray)?
◯ Less than one year
◯ 1-2 years ago
◯ More than 2 years ago
◯ I have never had one
◯ Don't know
◯ Not applicable (I have had a double mastectomy)

When was the last time you had your breasts examined by a health professional (a clinical breast exam)?
◯ I have never had a clinical breast exam
◯ Within the past year
◯ 1-3 years ago
◯ More than 3 years ago
◯ Don't know
◯ Not applicable (I have had a double mastectomy)

How long has it been since your last Pap smear?
◯ I have never had one
◯ Less than one year
◯ 1-2 years ago
◯ 2-3 years ago
◯ More than 3 years ago
◯ Don't know

Have you had a test for chlamydia within the past year?
◯ Yes
◯ No
◯ Don't know

Have you ever had a baby weighing more than nine pounds at birth?
◯ Yes
◯ No

Have you ever been diagnosed with gestational diabetes (diabetes that developed during pregnancy)?
◯ Yes
◯ No

FOR MALES ONLY

How often do you do a testicular self-exam?
◯ Not applicable
◯ Monthly
◯ Once every few months
◯ Rarely or never

How long has it been since your last prostate exam?
◯ Less than one year
◯ 1-2 years ago
◯ More than 2 years ago
◯ Never
◯ Don't know

Have you had a blood test for PSA (prostate specific antigen) in the past year?
◯ Yes
◯ No
◯ Don't know

PRODUCTIVITY

How would you describe your employment, your work schedule, and your pay type?

Employment Status
◯ Full time
◯ Part time

Work Schedule
◯ Regular schedule; day shift (roughly the same hours every day)
◯ Regular schedule; evening shift (roughly the same hours every day)
◯ Regular schedule; night shift (roughly the same hours every day)
◯ Rotating schedule (e.g., working a day shift some days and an evening or night other nights)
◯ Irregular schedule (e.g., unpredictable hours controlled by situations or workload)

Pay Type
◯ Salaried ("Salaried" means that you're paid the same amount each week or month no matter how many hours you work)
◯ Hourly ("Hourly" means that you're paid a different amount each week or month depending on how many hours you work)

In the past two weeks, how many full workdays did you miss because of your health or medical care?

_____ Enter number of days

In the past two weeks, what was the total number of days you missed part of a workday because of your health or medical care? (Do not count any days where you missed the full work day)

_____ Enter number of days

Health problems can make it difficult for working people to perform certain parts of their jobs. We are interested in learning about how your health may have affected you at work during the past 2 weeks.

The questions will ask you to think about your physical health or emotional problems. These refer to any ongoing or permanent medical conditions you may have and the effects of any treatments you are taking for these. Emotional problems may include feeling depressed or anxious.

The following questions ask about how your health has affected you at work during the past 2 weeks. Please answer these questions even if you missed some workdays.

- Mark the "Does not apply to my job" box only if the question describes something that is not part of your job.

- If you have more than one job, report on your main job only.

In the past 2 weeks, how much of the time did your physical health or emotional problems make it difficult for you to do the following?

Get going easily at the beginning of the workday
◯ Difficult all the time (100%)
◯ Difficult most of the time
◯ Difficult some of the time (about 50%)
◯ Difficult a slight bit of the time
◯ Difficult none of the time (0%)
◯ Does not apply to my job

Start on your job as soon as you arrived at work
◯ Difficult all the time (100%)
◯ Difficult most of the time
◯ Difficult some of the time (about 50%)
◯ Difficult a slight bit of the time
◯ Difficult none of the time (0%)
◯ Does not apply to my job

This question asks you to rate the amount of time you were able to handle certain parts of your job without difficulty.

In the past 2 weeks, how much of the time were you able to sit, stand, or stay in one position for longer than 15 minutes while working, without difficulty caused by physical health or emotional problems?
◯ Able all the time (100%)
◯ Able most of the time
◯ Able some of the time (about 50%)
◯ Able a slight bit of the time
◯ Able none of the time (0%)
◯ Does not apply to my job

In the past 2 weeks, how much of the time were you able to repeat the same motions over and over again while working, without difficulty caused by physical health or emotional problems?

◯ Able all the time (100%)
◯ Able most of the time
◯ Able some of the time (about 50%)
◯ Able a slight bit of the time
◯ Able none of the time (0%)
◯ Does not apply to my job

This question asks about difficulties you may have had at work.

In the past 2 weeks, how much of the time did your physical health or emotional problems make it difficult for you to do the following:

Concentrate on your work

◯ Difficult all the time (100%)
◯ Difficult most of the time
◯ Difficult some of the time (about 50%)
◯ Difficult a slight bit of the time
◯ Difficult none of the time (0%)
◯ Does not apply to my job

The next question asks about difficulties in relation to the people you came in contact with while working. These may include employers, supervisors, coworkers, clients, customers, or the public.

In the past 2 weeks, how much of the time did your physical health or emotional problems make it difficult for you to do the following?

Speak with people in person, in meetings, or on the phone

◯ Difficult all the time (100%)
◯ Difficult most of the time
◯ Difficult some of the time (about 50%)
◯ Difficult a slight bit of the time
◯ Difficult none of the time (0%)
◯ Does not apply to my job

In the past 2 weeks, how much of the time did your physical health or emotional problems make it difficult for you to do the following?

Handle the workload

◯ Difficult all the time (100%)
◯ Difficult most of the time
◯ Difficult some of the time (about 50%)
◯ Difficult a slight bit of the time
◯ Difficult none of the time (0%)
◯ Does not apply to my job

Finish work on time

◯ Difficult all the time (100%)
◯ Difficult most of the time
◯ Difficult some of the time (about 50%)
◯ Difficult a slight bit of the time
◯ Difficult none of the time (0%)
◯ Does not apply to my job

What is your annual income from your job, before taxes/or if paid by the hour, how much are you paid per hour, before taxes?
(Select either annually or hourly)

Annually

◯ Less than $5,000
◯ $5,000 — $9,999
◯ $10,000 — $14,999
◯ $15,000 — $19,999
◯ $20,000 — $24,999
◯ $25,000 — $29,999
◯ $30,000 — $34,999
◯ $35,000 — $39,999
◯ $40,000 — $44,999
◯ $45,000 — $49,999
◯ $50,000 — $54,999
◯ $55,000 — $59,999
◯ $60,000 — $64,999
◯ $65,000 — $69,999
◯ $70,000 — $74,999
◯ $75,000 — $99,999
◯ $100,000 — $149,999
◯ $150,000 — $199,999
◯ $200,000 — $299,999
◯ $300,000 — $499,999
◯ $500,000 — $999,999
◯ $1,000,000 or more
◯ I prefer not to answer

Hourly

◯ $5.00 — $8.00
◯ $8.01 — $10.00
◯ $10.01 — $12.00
◯ $12.01 — $14.00
◯ $14.01 — $16.00
◯ $16.01 — $18.00
◯ $18.01 — $20.00
◯ $20.01 — $22.00
◯ $22.01 — $24.00
◯ $24.01 — $26.00
◯ $26.01 — $29.00
◯ $29.01 — $32.00
◯ $32.01 — $35.00
◯ $35.01 — $38.00
◯ $38.01 — $41.00
◯ $41.01 — $45.00
◯ $45.01 — $50.00
◯ $50.01 — $55.00
◯ $55.01 — $60.00
◯ $60.01 — $70.00
◯ $70.01 — $80.00
◯ $80.01 — $90.00
◯ $90.01 — $100.00
◯ More than $100.00
◯ I prefer not to answer

BIOMETRICS 2

What units of measure do you want to enter for your blood work values?

◯ mg/dL (Conventional Units - typically used in the United States)
◯ mmol/L (Standard International Units - typically used outside United States)

Blood pressure

◯ **Systolic blood pressure** _____ Enter value

◯ **Diastolic blood pressure** _____ Enter value

If you did not enter a value for your blood pressure, please give your best estimate:

◯ I don't know my blood pressure, but I have been told that it is HIGH.
◯ I don't know my blood pressure, but I have been told that it is NORMAL.
◯ I don't know my blood pressure, but I have been told that it is LOW.
◯ I don't know anything about my blood pressure.

Cholesterol

◯ **Total Cholesterol** _____ Enter value

If you did not enter a value for your total cholesterol, please give your best estimate:

◯ I don't know my total cholesterol, but I have been told that it is HIGH.
◯ I don't know my total cholesterol, but I have been told that it is NORMAL.
◯ I don't know my total cholesterol, but I have been told that it is LOW.
◯ I don't know anything about my total cholesterol.

◯ **HDL Cholesterol** _____ Enter value

If you did not enter a value for your HDL cholesterol ("good cholesterol"), please give your best estimate:

◯ I don't know my HDL cholesterol, but I have been told that it is at the recommended level.
◯ I don't know my HDL cholesterol, but I have been told that it is lower than it should be.
◯ I don't know anything about my HDL cholesterol.

◯ **LDL Cholesterol** _____ Enter value

If you did not enter a value for your LDL cholesterol ("bad cholesterol"), please give your best estimate:

◯ I don't know my LDL cholesterol, but I have been told that it is higher than it should be.
◯ I don't know my LDL cholesterol, but I have been told that it is at the recommended level.
◯ I don't know anything about my LDL cholesterol.

Triglycerides _____ Enter value

Was this a fasting bloodwork (at least 9 hours)?

◯ Yes
◯ No

If you did not enter a value for your triglycerides, please give your best estimate:

◯ I don't know my triglyceride level, but I have been told that it is higher than it should be.
◯ I don't know my triglyceride level, but I have been told that it is at the recommended level.
◯ I don't know anything about my triglyceride level.

Blood glucose _____ Enter value

Was this a fasting bloodwork (at least 8 hours)?

◯ Yes
◯ No

If you did not enter a value for your blood glucose, please give your best estimate:

◯ I don't know my blood glucose, but I have been told that it is HIGH.
◯ I don't know my blood glucose, but I have been told that it is NORMAL.
◯ I don't know anything about my blood glucose.

% Body Fat _____ Enter value

HbA1c _____ Enter value

Do you have any of the following symptoms?

Frequent urination	◯ Yes	◯ No
Excessive thirst	◯ Yes	◯ No
Extreme hunger	◯ Yes	◯ No
Unusual weight loss	◯ Yes	◯ No
Increased fatigue	◯ Yes	◯ No
Irritability	◯ Yes	◯ No
Blurry vision	◯ Yes	◯ No

THANK YOU FOR TAKING TIME TO COMPLETE THIS HEALTH ASSESSMENT.